HEALTHY FAMILIES AND
MEDI-CAL FOR FAMILIES PROGRAMS
EE Reimbursement Discontinuance Request Form

*Although you have met the eligibility requirements to receive application assistance reimbursement payments from the Healthy Families Program, your organization has the right to request **NOT** to receive any future payments. In order for the Healthy Families Program to confirm your request, it is required that you provide this request in writing by completing and forwarding this form to Healthy Families.*

DATE FORM SUBMITTED	
ENROLLMENT ENTITY (EE) AUTHORIZED CONTACT ORIGINAL SIGNATURE	
EE AUTHORIZED CONTACT NAME (please print)	
EE NUMBER	
EE NAME	
EE TELEPHONE NUMBER	
EE E-MAIL ADDRESS	

In the space provided below, please include the primary reason why you are requesting to stop receiving application assistance reimbursement payments. If you feel it is necessary to include an attachment with this form, please feel free to do so.

☐ Check this box if primary reason is due to receiving Grant Funds for application assistance activities. What are the Grantor's name and telephone and mailing contact information?

_____
_____
_____

What is the Grant's scope of work which you feel disqualifies you from receiving application assistance reimbursement payments?

_____
_____
_____

☐ Other (please explain below).

_____
_____

☐ Check attached. Check Number_____ Check Amount_____

☐ Additional documentation attached

Please mail all correspondence to: Healthy Families: EE/CAA Liaisons
625 Coolidge Dr, Folsom, CA 95630